AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) FOR ANTI-STIGMA CAMPAIGN

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH (LACDMH)

I authorize the use and disclosure of my protected health information (PHI) as described below:

CLIENT/INDIVIDUAL IDENTIFICATION

First Name _____ **Last Name** _____

Street Address _____ **City, State, Zip** _____

IS Number _____ **Birth Date** _____ **Phone Number** ( )_____

DISCLOSING PARTY - RECIPIENT OF PHI

This authorization allows: LACDMH to use and/or to disclose my PHI, as described below, to Legislators, MHSA community stakeholders, the media, and the general public, including posting on DMH's internet website.

REDISCLOSURE NOTICE:
I understand that my PHI which is used or disclosed pursuant to this Authorization may no longer be protected by Federal Law and could be further used or disclosed by the recipient without my authorization. I also understand that once my information is disclosed, it may not be possible to retrieve.

DESCRIPTION OF PHI & PURPOSE

Description of PHI to be Disclosed:
My personal story of recovery, related artworks, writings, photographs of me, audio recordings of me, and/or video recordings of me.

Purpose of Disclosure:
My PHI may be used in various forms for the following purposes: advocacy, literary publications, electronic publications, Internet publications, public relations materials, educational materials, and/or training materials.

Neither LACDMH nor any person signing this Authorization will receive any direct or indirect remuneration.

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N O T I C E

COPY OF THIS AUTHORIZATION: I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

CONDITIONS: I understand that I may refuse to sign this Authorization without affecting my ability to obtain treatment.

Special Notice *to paid or non-paid staff including volunteers, interns, contractors, locum tenens, peer advocates, and mental health consumers who act as volunteers for LACDMH and consumers and their families: LACDMH will not take any intimidating or retaliatory acts against anyone who does not wish to disclose their PHI or sign this Authorization.*

EXPIRATION DATE

Expiration Date: Date may not exceed five (5) years from the date signed. If no expiration date is indicated, expiration date will expire five (5) years from the date signed. This authorization is valid until: _____

I have had an opportunity to review and understand the content of this Authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

_____ _____

Signature of Client/Individual/Personal Representative **Date**

If signed by other than client, state relationship and authority to do so: _____

REVOCATION OF AUTHORIZATION: I understand that I have the right to revoke this authorization at any time in writing. I may use the Revocation of Authorization Section of this form, mail or deliver the revocation to Kathleen Piche, LCSW, LAC-DMH Public Information Officer, 550 S. Vermont Ave., 6th Floor, Los Angeles, CA 90020. I also understand that a revocation will be effective upon receipt, but will not be effective as to uses and/or disclosures of my protected health information already made in reliance on this Authorization.

REVOCATION OF AUTHORIZATION

_____ _____

Signature of Client/Individual/Personal Representative **Date**

If signed by other than client, state relationship and authority to do so: _____